AU/ACSC/2011

AIR COMMAND AND STAFF COLLEGE

AIR UNIVERSITY

A CASE STUDY INVESTIGATION INTO CREATING A JOINT PHYSICAL EVALUATION BOARD

by

Elizabeth K. Blanchford, Major, USAF

A Research Report Submitted to the Faculty

In Partial Fulfillment of the Graduation Requirements

Instructor: Dr Richard Smith

Maxwell Air Force Base, Alabama

April 2011

APPROVED FOR PUBLIC RELEASE – DISTRIBUTION UNLIMITED

Disclaimer

The views expressed in this academic research paper are those of the author(s) and do not reflect the official policy or position of the US government or the Department of Defense. In accordance with Air Force Instruction 51-303, it is not copyrighted, but is the property of the United States government.

Table of Contents

List of Figures

Preface

I recently joined the Physical Disability Board of Review (PDBR) team to help prepare cases for adjudication. In the process of reading individual service members cases, I have become very interested in the system and have gained an increased awareness of the challenges service members face as they move through the military disability evaluation process. The idea for this research topic came out of a conversation with Mr. Mike LoGrande, PDBR Board President. In the process of helping me develop this idea and connecting me with valuable subject matter experts, he has become my mentor. I am exceedingly thankful for the time and attention he provided in helping me complete this thesis.

I would also like to thank my instructor and advisor, Dr. Richard Smith who provided just the right amount of guidance and demonstrated significant understanding, despite a major shift in my research at the last minute. Without his support and suggestions, this paper would not have been possible. Finally, I would like to thank my friends and family for their support as I worked on this paper. I would like to express my heartfelt appreciation to my husband, Andy, and our two very young children, Isabella and Aiden, whose patience and encouragement allowed me to focus almost single-mindedly on completing this thesis.

Abstract

In 2007, in the wake of the investigations of Walter Reed Army Medical Center, Congress showed increased interest in the proper care of our nation's military members, especially those who were wounded, ill or injured. The Department of Defense (DoD) Disability Evaluation System (DES) drew further scrutiny by Congress as a result of numerous complaints that the Services were inconsistently rating Soldiers, Sailors, Airmen and Marines with similar injuries. On January 28, 2008, the National Defense Authorization Act (NDAA) was signed into law by President George W. Bush. This Wounded Warrior legislation instituted a number of critical changes to the DES process. First, it required the DoD and the Veterans Administration (VA) to integrate the current DES into a single streamlined process, better serving the veterans and saving the DoD money. Second, it mandated the establishment of a joint PDBR created to review, upon appeal, veterans' cases with medical conditions for individuals with a disability rating 20% or less and, consequently, were ineligible to retire when medically discharged.

The purpose of this research was to determine the efficiencies, benefits and challenges of continuing these joint trends toward the creation of a joint Physical Evaluation Board (PEB). To justify the recommendation of developing a joint PEB, a case-study methodology is used to compare the current individual Services' PEB structures to the joint PDBR construct. Successes garnered by the joint PDBR and Integrated Disability Evaluation System (IDES) provide a benchmark for further joint efforts. The PEB and PDBR were compared using dependent variables designed to characterize efficiency, effectiveness, cost savings and the benefit to the service member. The results of this research found the pooling of personnel resources demonstrates significant cost savings to the DoD, improves the DES timeline, ensures greater consistencies in ratings and creates opportunities for cross-flow between the Services. A joint PEB construct would be beneficial to both the DoD and the service member.

CHAPTER I
INTRODUCTION

"Far too many are suffering from the signature injuries of the wars in Iraq and Afghanistan – Post Traumatic Stress Disorder and Traumatic Brain Injury…. The service men and women who embody what is best about America should get the best care we have to offer."

Barack Obama,
President of the United States[1]

The concept of serving those who have served our country has long been part of America's historical consciousness. Recognition of that responsibility has been in place since the arrival of the Pilgrims at Plymouth in 1636. Their established standards provided that any soldier who should return maimed from the defense of the settlers should be maintained by the colony for the rest of his life.[2] President Lincoln reaffirmed this moral obligation to ". . . care for him who shall have borne the battle and for his widow and his orphan."[3] In 1930, Executive Order 5398 was signed by President Herbert Hoover consolidating the U.S. Veterans' Bureau, the National Homes for Disabled Soldiers and the Bureau of Pensions into the new Veterans Administration (VA). In 1989, the VA was elevated to a Cabinet-level agency and became the Department of Veterans Affairs.[4]

Although the practice of compensating injured soldiers dates back as far as Colonial times, the current compensation system has its roots in World Wars I and II. In 1917 Congress mandated the development of disability ratings and in 1949 the Career Compensation Act linked the amount of payments to the degree of disability.[5] This Act established the 30% threshold that is still the 'magic number' today. According to Mr. Rick Surratt, Deputy Legislative Director of Disabled American Veterans, ". . . the thinking was, those rated less wouldn't be so handicapped as to warrant long-term disability pay; instead a lump sum would hold them until they could get reestablished in the workplace."[6]

What the DES process attempts to do is, ". . . approximate the average loss of earnings capacity" says Mr. Tom Pamperin, Associate Deputy Undersecretary for Policy and Program Management of the Department of Veterans Affairs.[7] And, according to the Secretary of the Navy Instruction 1850.4E, Disability Evaluation Manual,

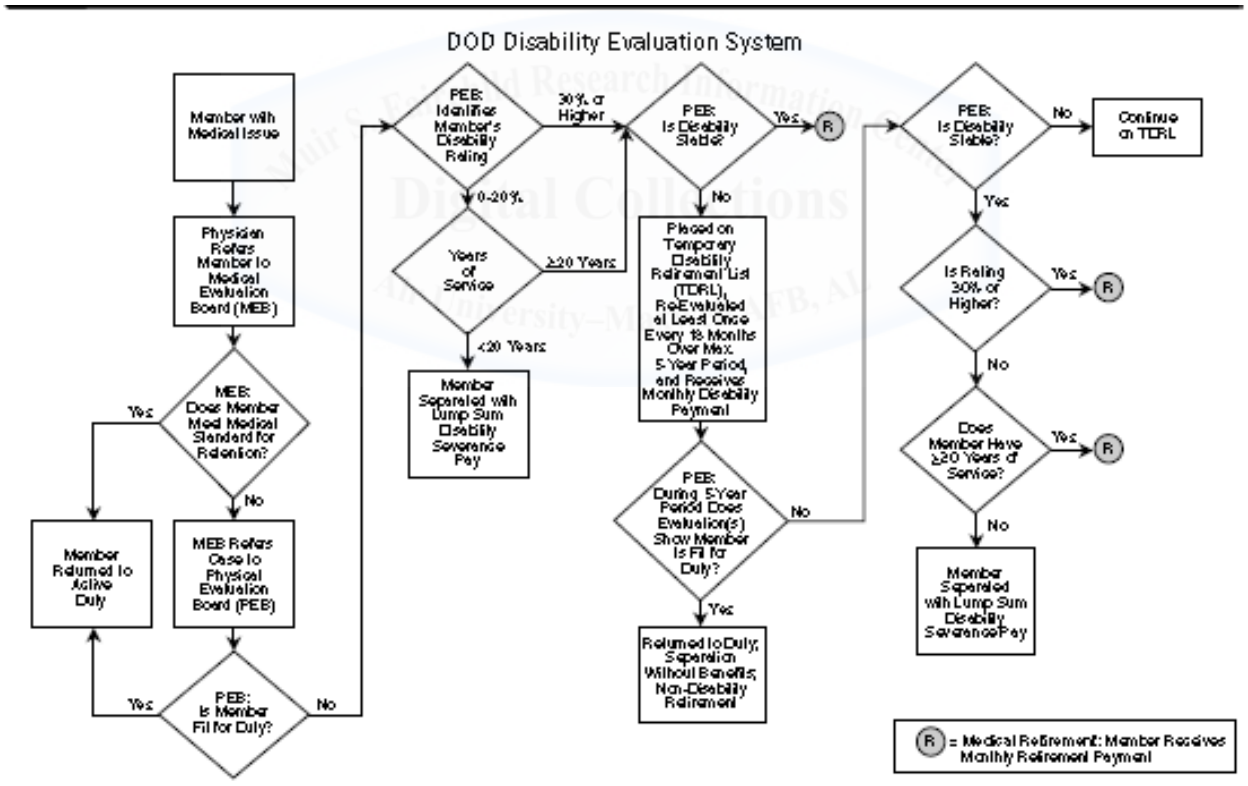
> The Physical Evaluation Board (PEB) is a fact-finding board that evaluates all cases of physical disability on behalf of the Marine/Sailor and the Service in accordance with the Secretary of the Navy Instruction 1850.4E (Disability Evaluation Manual). The PEB investigates the nature, cause, degree of severity, and probable permanency of the disability concerning the service member referred to the board. The board evaluates the physical condition of the service member against the physical requirements of his/her particular office, grade, rank or rating. The PEB provides a full and fair hearing as required by § 1214, Title 10 United States Code (10 U.S.C 1214), and makes findings and recommendations required by law to establish the eligibility of a service member to be retained on active duty due to fitness, or separated or retired from the service because of a physical disability.[8]

Nearly 20,000 service members are separated from the military each year for physical disabilities ranging from knee pain to mental illness.[9] Due to deployments in support of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), 42,560 service members have returned from combat wounded in action, causing higher numbers of service members to meet PEBs.[10] In fact, since 2001 the Army's caseload alone has climbed by more than 80% and the Army Physical Disability Agency (USAPDA) has added 50% more staff to keep up with this sharp rise in disability cases.[11] The Air Force has seen similar trends with over 7,000 cases in 2010 as compared with only 3,000 in 2001.[12] Based on a survey conducted by the Government Accountability Office (GAO), it is estimated that more than 500,000 veterans returning from these operations are likely to suffer from at least one of the three signature injuries of the war – Post Traumatic Stress Disorder (PTSD), Major Depression, or Traumatic Brain Injury (TBI).[13] These specific disabilities account for a significant amount of the current

PEB's caseload and also account for many of the inconsistent ratings that are discussed in this paper.

Disability Evaluation System

The DES includes several components outlined in figure 1: Medical Treatment Facility (MTF), Medical Evaluation Board (MEB), Informal Physical Evaluation Board (IPEB), and the Formal Physical Evaluation Board (FPEB). The process generally starts with the commanding officer or a physician referring the service member to an MTF. The MTF treats the member and can make a recommendation that he or she be sent to a MEB. The MTF then prepares a narrative



Source: GAO analysis of DOD documents.

Figure 1. DOD Disability Evaluation System. (Reprinted from a 2001 GAO Report on DoD Disabilities.)

summary of the major complaints and forwards that document to the MEB, which provides the medical explanation of the illness or injury. The only question the MEB answers is whether a member meets the retention standards for their job.[14] The IPEB reviews the MEB documentation and renders a decision as to the fitness or unfitness of the military member's conditions and also assigns a final disability rating. The service member can either accept this decision or elect to appeal to a FPEB. If the service member elects to proceed to a Formal PEB they have the right to be present with a lawyer when the FPEB adjudicates the case. The Director of the Review Board Agencies for Army and Air Force, Assistant Secretary of the Navy or Assistant General Counsel for the Navy then review the board recommendations and finalize the decisions.

While there are appeal processes both within each Service and at the DoD level, the PEB is the final step in the DES where a fit/unfit decision is rendered. Currently each Service manages their own PEBs to adjudicate cases within their Service. When service members meet a PEB, there are multiple possible outcomes. First, the PEB can find them fit for duty and return them either to their previous unit and duty position, or in the Army they can be re-categorized to a unit and job that accommodates their disabilities. In 2000, 18% of the service members meeting a PEB were returned to duty.[15] In 2010, only 12% of personnel were returned to duty due to the tremendous number of soldiers wounded in action.[16] In fact, Col Gail Gerding, former President of the Army PEB, says that, "In 2009 only 7% of Army service members meeting a board were found fit and returned to duty."[17]

If, as is generally the case, the member is found unfit, the PEB makes a determination of medical retirement or disability severance pay based on the final disability rating awarded. A 30% or higher rating means the service member will be awarded a medical retirement with full

TRICARE benefits for them and their family for the remainder of their lives. The service member and their family will also be eligible for military identification cards providing them access to base services such as the Base Exchange, commissary, lodging, MTF and travel on government transport. The medical retirement compensation amount is calculated as:

Disability Rating x Retired Monthly Base Pay*

Or

Years of Service x 2.5 x Retired Monthly Base Pay

*Retired base pay for those entering military service after September 7, 1980, is the average of the highest 36 months of basic pay.[18]

There is no published figure for the benefits package; however, TRICARE advertises that their benefits are comparable to an annual premium of $3,000 for a family with one child.[19] According to a GAO Report from 2000, 14% of all military members meeting a PEB were medically retired and received an average of $13,060 per year in medical retirement pay.[20] The total financial outlay for medical retirement pay in FY00 was $1.27 billion.[21] Medical retirement rates have actually increased to 22% in the decade since (see figure 5).[22] This 8% increase, plus the doubling of case numbers, has nearly tripled medical retirement costs.

A majority of service members that meet medical boards are instead awarded a 20% or lower final disability rating, which means they are offered a lump sum severance check and can then petition to the VA for further consideration. The amount of severance pay is calculated as:

Monthly Base Pay x 2 x Years of Service (up to a maximum of 12 years)[23]

In 2000, 35% of service members who met a PEB were awarded severance pay with the average member receiving a lump-sum payment of $18,725.[24] The total financial outlay for disability severance pay in FY00 was $159 million.[25] The percentage has changed little in ten years;

however, the number of service members in this category is now 5,843 and more soldiers are receiving higher payments due to combat related injuries.

Some veterans groups feel the Services are using a 'disposable mentality' with those who put themselves in harm's way to protect the nation. Richard Twohig, a former Army soldier, is one example of this situation. After falling on his head from a moving armored vehicle in Baghdad in 2003, he now suffers near constant migraine headaches that preclude him from working. He waited 17 months for the PEB results and found out he was rated 10% disabled. The FPEB made no changes and he was separated from the Army with severance pay. Within months the VA rated him 100% disabled – 50% for his headaches and 70% for his cognitive mood disorder. At age 25, with two children and a failing marriage, his biggest frustration was feeling abandoned by the Army. He enlisted; he trained; he followed orders and he went to war.[26] Now that he has paid the price he feels, "…they don't really care about soldiers...they got their mission and after we are no good to them, they just get rid of us."[27]

Current PEB Structure

Each Service currently uses a slightly different method for entering a service member into the DES. According to a joint handbook created by the VA and DoD in 2008, "The Army…uses a physical profile system that measures soldiers' physical limitations in six areas with a level between 1 (fully healthy) to a 4 (severely limited) in each."[28] Once a soldier is assigned a permanent 3 or 4 in any area, a physician is required to recommend that a MEB review the soldier's case. The Navy/Marine Corps on the other hand, does not require a prior profile in order for a service member to be forwarded to a MEB. A physician can write a narrative summary at any time and send it up for consideration. The Air Force takes a slightly

different approach as well. In the opinion of LtCol Lorrainne Hodge, an AF PEB adjudicator, "The Army typically evaluates based on a soldier's current enlistment, while the Air Force considers more long term implications of career retention when making their PEB fit/unfit determinations."[29] This is evidenced in the system the Air Force utilizes whereby a member is assigned a limitation code when a physician determines a particular condition to limit his or her duty performance within the particular Air Force specialty. The member will be reevaluated at a later date and if the condition is not expected to improve within 12 months, and the condition is permanently unfitting, they will then be referred to a MEB. The by-product of this system is that the Army and Navy may occasionally retain members that have long term illnesses/injuries that fluctuate in severity, while the Air Force will generally separate those individuals. LtCol Hodge gave examples such as asthma and Crohn's Disease.[30]

The Air Force IPEB is located at the Air Force Personnel Center at Randolph Air Force Base. The baseline personnel structure is 7 adjudicators and 11 administrators.[31] Depending on workflow the board will bolster their numbers with Reservists and medical continuation personnel utilizing man-days. Last year's caseload was approximately 7,000 when factoring in the backlog.[32] LtCol Leslie Hargett, Director of the AF PEB, says that, "There are never enough adjudicators, medical professionals or administrative staff to get the job done as quickly as we would like."[33] This is a sentiment that was shared by each of the Services PEB directors. According to LtCol Hargett, ". . . the IPEB is operated on a quota system, whereby the output has to match the input…some months it is 400 cases."[34] The official requirement is to have an IPEB decision within 40 days of the case reaching the PEB; however, LtCol Hargett's team's goal is to have a decision within 14 days. Admittedly processing time has been as high as 120 days in the past due to high surge periods.[35]

The Navy/Marine Corps has a similar structure to the Air Force, with only one PEB located at the Navy Yard in Washington D.C. The baseline personnel structure is an average of 13-15 adjudicators, four of whom are physicians and the remainder line officers. The administrative staff is broken up between Physical Evaluation Board Liaison Officer (PEBLO) functions, Temporary Disability Retired List (TDRL), records section, and a president with an executive and an executive assistant, totaling approximately 14 administrative personnel. Last year's caseload for the Navy/Marine Corps PEB was 4,164 with an average of 30-50 cases processed a day.[36] LtCol Stephen Eckberg, former Navy PEB officer, estimates that the physician probably spends an hour per case and then each of the two line officers less than an hour, for a total of two to three hours per case.[37] In 2009, during his time at the Navy PEB, the average backlog was less than 100 cases and most were processed within one to two months of reaching the PEB.

One of the key differences between the Navy PEB and the other Services is the pooling of manpower for both the IPEB and FPEB. Both the Air Force and the Army have separate boards to support only the FPEB process. The Navy utilizes the same adjudicators and physicians for both PEBs. FPEBs are generally held on Tuesday and Thursday each week with an average of four to five a day, when there are formal cases to be heard. According to LtCol Eckberg, this labor pooling helps to keep workflow steady and maintain a minimal backlog.[38]

The Army PEB is much more complex with three fixed PEBs and a mobile PEB to fill in as needed. The caseload is distributed based on region, instead of the centrally managed system of the other Services. Each PEB consists of two doctors, two line officers, a PEB president and four administrative staff.[39] The mobile PEB is one team with a doctor, line officer and president. There are additional personnel authorizations that are generally made up of Reservists who float

between PEBs. These include two additional doctors, four line officers and four to six administrative staff. There are also another 25-30 personnel supporting the USAPDA that oversees the Army's DES process. According to Col Gerding, "Each PEB adjudicates approximately 20-25 cases per day" in order to meet the 15,320 cases boarded in 2010.[40] The Army is predicting an influx of 40,000 additional Reserve disability cases for 2011 and is standing up a forth temporary PEB in Florida, nearly doubling their PEB personnel.[41]

One similarity across the Services is the format of the FPEB. If a member disagrees with the IPEB decision, they have the right to appeal the decision to a formal board. No matter the Service, members may seek legal counsel (either military or civilian) to represent them at this formal hearing. Service members have a right to testify and present material on their own behalf at these boards and have their TDY expenses paid in order to attend.

CHAPTER II
WOUNDED WARRIOR LEGISLATION

"Requires, not later than Jan. 1, 2008, and updated at least annually, DoD and VA, in consultation with heads of other relevant federal departments and agencies, to jointly develop and implement a comprehensive policy on the care and management of covered servicemembers. Scope shall include care and management, medical and disability evaluation, return to duty when appropriate, and transition from DoD to VA; and consider findings of several listed committees, task forces and other sources."[42]

- Wounded Warrior Legislation, H.R. 1538

In 2007, in the wake of the investigations of the Walter Reed Army Medical Center, Congress showed increased interest in the proper care of our nation's military members, especially those who were wounded, ill or injured. These investigations acknowledged the sub-standard living conditions and poor treatment of service members and led to the resignation of former Secretary of the Army Francis Harvey. The Chairman of the Senate Armed Services Committee, Subcommittee on Personnel at the time, Senator Benjamin Nelson later stated in the hearing that, ". . . service members are fighting their way through a bungled, adversarial administrative process."[43] He described the way many service members were not properly accounted for in the transition between the DoD and VA process since they were forced to start over. Senator Carl Levin, D-Mich., Chairman and Ranking Member of the Armed Services Committee, went on to proclaim, "The war in Iraq has divided our nation but the cause of supporting our troops unites us. We will do everything we can possibly do — not as Democrats or Republicans — but as grateful Americans — to care for those who have served our nation with such honor and distinction."[44]

The DES drew further scrutiny from Congress as a result of numerous complaints that the services were inconsistent in treating Soldiers, Sailors, Airmen and Marines with similar injuries. For example, the Army was making disability rating decisions based on the USAPDA 'pain

policy' adopted from Army Regulation (AR) 635-40, Personnel Separations: Physical Evaluation for Retention, Retirement, or Separation.[45] This policy established maximum ratings of 20% based on American Medical Association (AMA) definitions of pain severity and eliminated consideration of pain as a limitation of joint movement. This is ubiquitous in spine and other medical conditions where the range of motion evaluation is the basis for the Veterans Affairs Schedule for Rating Disabilities (VASRD) rating.[46] The Army pain policy has been a significant point of contention given the steady growth in acute injuries that have progressed to the level of chronic pain due to the strains of war. According to the Department of Veterans Affairs, ". . . veterans of the wars in Iraq and Afghanistan who retired with musculoskeletal conditions grew tenfold between 2003 and 2009."[47]

These inconsistencies necessitated change which came on January 28, 2008 when the National Defense Authorization Act (NDAA) was signed into law by President George W. Bush. Legislation adopted and incorporated into the 2008 NDAA is referred to as the Dignified Treatment of Wounded Warriors Act (or Wounded Warrior Legislation). On April 29, 2009, Senator Benjamin Nelson, commented that, ". . .the Departments have been tasked with great challenges, such as jointly developing a fully interoperable electronic health record, improving the disability evaluation system (DES), establishing centers of excellence for psychological health, traumatic brain injury (TBI), and much more."[48]

One section of the Wounded Warrior Legislation required the DoD to establish a PDBR. The PDBR reviews appeal cases from veterans with medical conditions that resulted in discharge from the Service with a Service disability rating of 20% or less and therefore were ineligible for medical retirement upon separation. The review evaluates whether, under the applicable guidance in effect at the time, the rating awarded was fair and accurate.[49] Veterans medically

separated by the DES between September 11, 2001 and December 31, 2009 are eligible to request this review.[50]

Inconsistent criteria and ratings across the Services have drawn considerable attention and scrutiny, particularly in cases involving PTSD. In 2008, a class action lawsuit brought by the National Veterans Legal Services Program contended that, ". . . the services illegally denied retiree status and medical benefits for years to these veterans who were diagnosed with PTSD then separated as unfit for service."[51] Seven veterans were named as original plaintiffs in what became known as the case of Sabo, et al vs. the United States. Service PEB's had been routinely ignoring the VASRD rating schedule which requires a minimum 50% rating for PTSD for at least six months. The PEBs routinely separated service members with various levels of PTSD with a 10% disability rating. More than 4,300 veterans were invited to participate in the class action lawsuit and could either apply to the PDBR or their respective Boards for Correction of Military Documents (BCMD) to have their records reviewed.[52] Just over 2,000 veterans opted into the class and of those 1,185 elected to have their documents reviewed by the PDBR.[53] According to PDBR President, Mr. Mike LoGrande, ". . . of the 186 Sabo cases already boarded, the PDBR has recommended a disability rating of 30% or greater in 94% of the cases."[54]

Another component to the Wounded Warrior Legislation was a direction to the Services to use VASRD rules as their adjudication baseline. This would require the PEBs to adjudicate cases with a common rule set. This requirement went into effect in 2009, thereby correcting the inconsistencies the PDBR was set up to address. Once the backlog of cases is reviewed, the PDBR will no longer be necessary. The VASRD is a comprehensive schedule covering the entire body and rating each injury/disability based on established criteria. Ratings are based on a 0 – 100 percent scale and are made in 10 percent increments. While there is still a level of

interpretation involved, the requirement to use this common standard has created significant transparency in rating disabilities.

Integrated Disability Evaluation System

The Wounded Warrior Legislation also required the DoD and VA to collaborate on many levels, leading to the development of the IDES. In November of 2007, the DoD and VA initiated a joint DES pilot program in the National Capital Region (NCR) in response to the President's Commission on Care for America's Returning Wounded Warriors, sometimes called the Dole-Shalala Report.[55] According to a 2008 GAO Report, the pilot project was developed to address more systemic concerns, ". . . such as the timeliness and potential inefficiency and variable outcomes of DoD's and VA's separate evaluation systems."[56]

Major General Keith Meurlin testified during the Wounded Warrior Act hearing on April 29, 2009 that,

> Now, as in the past, the DoD remains committed to providing a comprehensive, fair, and timely medical and administrative processing system to evaluate our injured or ill servicemembers' fitness for continued service using the DES. One way we have honored these men and women, was to develop and establish a DES pilot that provides one solution for a DoD and VA DES using one integrated disability rating system. This system has several key features: simplicity; non-adversarial processes; single-source medical exam and disability ratings (eliminating duplication); seamless transition to veteran status; and strong case management advocacy.[57]

The pilot project was so successful in the NCR that after the first year it expanded to more than 17 new MTF's nationwide. According to a 2010 GAO report, active service members who completed the DES pilot averaged 271 days from entry into the system to the VA benefits decision. This as compared to the prior legacy system where active duty Army cases averaged 369 days, with some surges extending to 540 days.[58] Figure 2 below demonstrates the

redundancies eliminated to create a process that is 47% faster than the current DES and VA legacy process.[59]

Due to the effectiveness of the pilot program, full integration to the IDES is expected by the end of FY12. According to the disposition chart in Figure 5, 23% of the cases boarded by the PEB's in FY10 were through the IDES.[60] The goal is to have a VA representative at every MTF that will guide the member through the claims paperwork. VA contracted physicians are conducting the medical assessments on the service members injuries/illnesses, which are then forwarded to the PEB for a fit/unfit determination. Once the PEB makes the fitness decision the documents are forwarded to the VA for the disability rating assessment. If all of the examination documents are clear and available this process generally takes two weeks. The VA rating decision is then returned to the PEB for final approval. PEBs are now required to accept the ratings and codes awarded to a member by the VA. This integrated system is changing the PEB process dramatically.

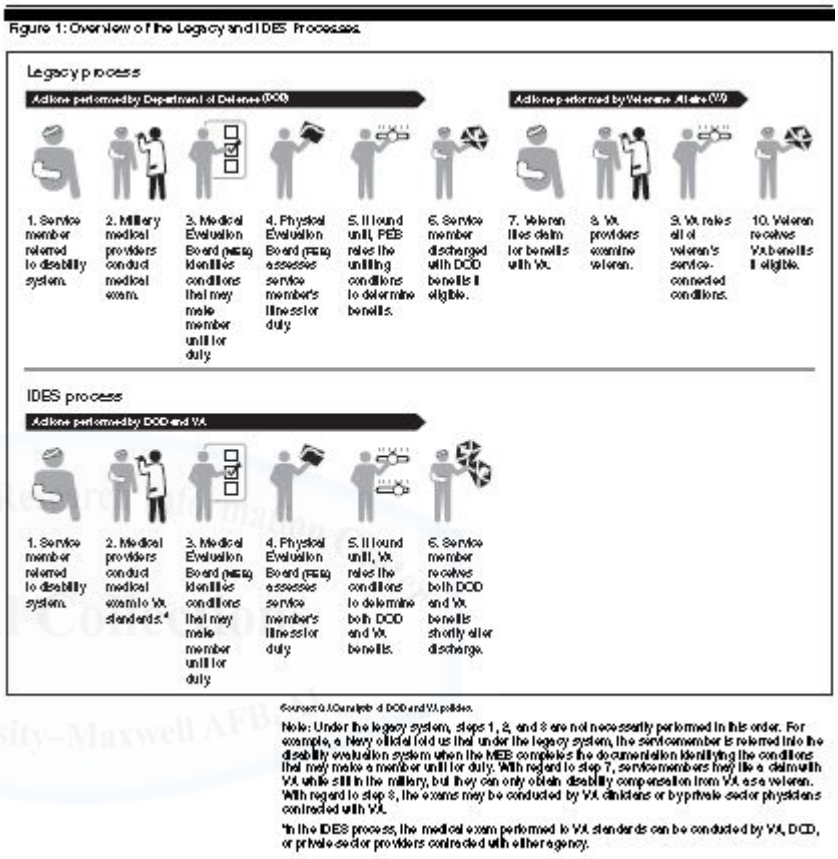


Figure 2. Comparison of Legacy and IDES Processes (Reprinted from 2010 GAO Report on Military and Veterans Disability Systems.)

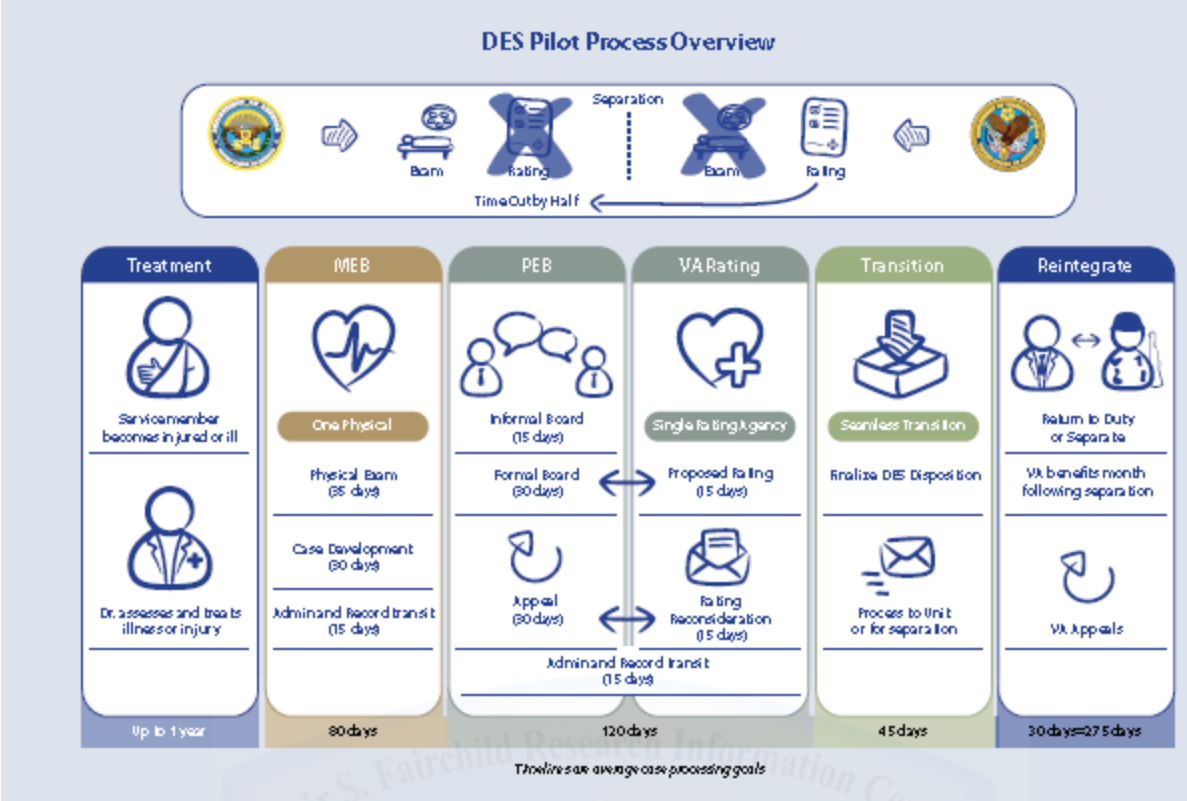


Figure 3. DES Pilot Process Overview (Reprinted from the Wounded, Ill and Injured Compensation and Benefits Handbook, 2008.)

First, it is improving the consistency and transparency across the Services and between the DoD and VA, a key goal of the Wounded Warrior Act. Second, the system reduces the workload on the PEB by focusing their efforts on making only a fitness determination. Third, there are substantial cost savings to the DoD not having to duplicate processes already in place by the VA. The DoD no longer has to pay for the medical examinations for the DES process, thereby relieving service physicians to take care of other patients and saving the taxpayers thousands of dollars in medical expenses. This is especially beneficial given the heavy burden on the MTF's and the fact that there are critical manning concerns across the Services for physicians.

Lastly, it is providing better service to the member, as outlined in figure 3 above. A VA representative guides the member through the process providing one point of contact from the time they enter the system. Now instead of having to work through the long DoD system and then start over with the VA, the two processes are working simultaneously. According to LtCol Hargett, there has been a great deal of discussion at the OSD level about, ". . . consolidating things and trying to make more parallel processes."[61] The proof is in the 47% faster outcomes of the pilot program.[62] The integrated system also reduces the wait times and helps ensure members are eligible for their benefits the day they separate. In the previous system it could take months or years for the transition to occur. Still, many at the Congressional level are still not satisfied with the 271 day timeline and are working to bring it below 180 days.[63] Figure 4 shows the IDES case processing times for each of the Services in 2010. Despite an improvement over previous years, most of the Services are still not meeting their workflow goal of 295 days. The only way to accomplish such a goal is by eliminating duplication of effort, inefficiencies and effectively utilizing critical resources.

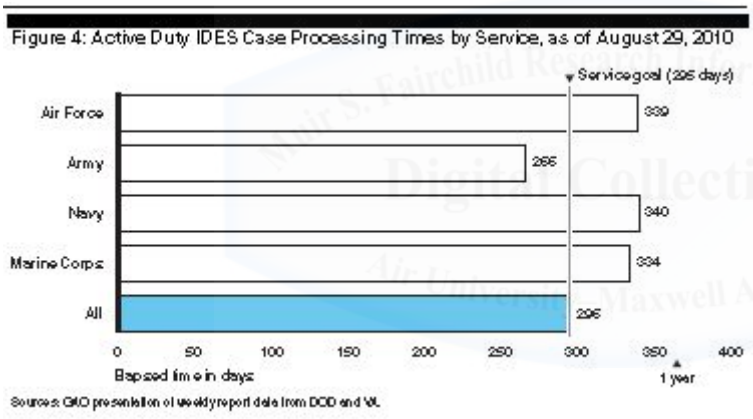


Figure 4. Active Duty IDES Case Processing Times by Service (Reprinted from 2010 GAO Report, Military and Veterans Disability System.)

By merging two duplicative disability evaluation systems, the IDES shows promise for expediting the delivery of benefits to service members being separated from the military due to a disability. According to a 2010 GAO report investigating the success of the IDES, "Servicemembers who proceed through the process are able to leave the military with greater

financial security, since they receive disability benefits from both agencies shortly after discharge. Further, having both DOD and VA personnel involved in reviewing each disability evaluation may result in a more thorough scrutiny of cases and informed decisions on behalf of servicemembers."[64] The IDES should be used as a benchmark to recommend other joint endeavors to further the efficiencies and cost savings already taking place.

Interoperability

The Wounded, Ill, and Injured Senior Oversight Committee (SOC) aligned all issues relating to both DoD and VA under the Joint Strategic Plan (JSP). The JSP details the collaborative future efforts to strengthen the capabilities of both Departments to better serve veterans. Major components of the JSP include; information management, information technology and information sharing.[65] The JSP detailed a plan to create the DoD/VA Interagency Program Office (IPO) which was established in April 2008, as mandated by Section 1635 of the NDAA.[66] According to Michael E. Kilpatrick, M.D., Director of Strategic Communications for the Military Health System in the Office of the Assistant Secretary of Defense for Health Affairs, "The IPO acts as the single point of accountability for the development and implementation of electronic health record (EHR) systems and capabilities and provides oversight and management of the delivery of interoperability goals and objectives."[67] The IPO has recently broadened its' scope to include President Obama's concept of creating a Virtual Lifetime Electronic Record, ". . . which would expand on the idea of fully interoperable electronic health record capabilities to include personnel, benefits and administration."[68]

The development of interoperable information management systems is a critical component to creating greater efficiencies across the healthcare system and throughout the

disability evaluation process. One of the great benefits of the virtual lifetime record idea is that it would leverage industry best practices along with investments already made in existing DoD and VA electronic record systems to create an interoperable network with new and legacy operations.[69] According to Rear Admiral Gregory A. Timberlake, USN, Director Interagency Program Office, DoD/VA, "The IPO – interagency program office – has centered its energies on ensuring the full interoperability of the electronic personal health information required for clinical care between DoD and VA."[70] In order to accomplish this he recommends the use of well known interoperability systems like the Federal Health Information Exchange and the Bidirectional Health Information Exchange in order to create greater efficiencies and tap into technology already available.[71]

This links directly into the concept of creating a joint PEB to integrate and share systems already in place. The technology and investments made in creating this interoperable record system provides the research and baseline for one of the major challenges in considering a joint PEB, the integration of common services and standardization of software.

Data sharing is a major strategic issue when attempting to create interoperable systems between organizations that have been independent since inception. This is especially true of the DES since all of the Services still use paper files. According to LtCol Leslie Hargett, the IPEB is just a "paper mill" with thousands of paper documents moving between facilities, centers, offices and cubicles.[72] Not only does this create an opportunity for documents to be lost, but it also causes a great deal of administrative oversight to manage the physical workload. There are tremendous inefficiencies with sending paper back and forth across the country and waiting for physical documents to be moved from desk to desk. The integration of this technology with the

virtual lifetime electronic record would allow for fast and effective movement of documents anywhere in the world.

Research Question

The Congressional instruction to improve the DES, thereby enhancing care for our service members, is a key element in this analysis. Another motivating factor is the economic incentive such a change would deliver. Military budget cuts are on the rise due to the recent economic crisis and the costs associated with fighting two extended wars. Government shutdowns are being threatened due to budget balancing challenges. For these reasons, joint operations are becoming standard practice across the DoD as a way to create efficiencies in manpower, resources, overhead and facilities. Mr. Mike LoGrande, PDBR President, feels strongly that, ". . . now more than ever with budgets being tight and escalating costs of operation, the DoD needs to find ways to realize savings internally. In my personal opinion this lends itself to the notion of increased jointness to reduce duplication of efforts in lower level positions, such as administrative support, as well as space and footprint efficiencies."[73] Mr. LoGrande makes the case that the joint PDBR construct is consistent with the principles of the Goldwater-Nichols Act encouraging joint activities for the purpose of efficiencies and effectiveness of a totally joint force.[74]

The Goldwater-Nichols Department of Defense Reorganization Act of 1986, sponsored by Sen. Barry Goldwater and Rep. Bill Nichols, caused a major Defense reorganization and made DoD joint operations standard practice. According to the National Defense University Library website, "Joint Vision 2010 and Joint Vision 2020, both emphasize that to be the most effective force we must be fully joint: intellectually, operationally, organizationally, doctrinally,

and technically. The joint force, because of its flexibility and responsiveness, will remain the key to operational success in the future."[75]

Creating a joint Physical Evaluation Board would lead to greater efficiencies for the DoD, standardized application of Congressionally directed rules and enhanced care for service members. Utilizing the Physical Disability Board of Review as a case study, this paper will investigate the potential benefits and efficiencies created in moving toward a joint Physical Evaluation Board. It will also compare three distinct options and make a final recommendation utilizing a case study methodology.

CHAPTER III
PHYSICAL DISABILITY BOARD OF REVIEW

The PDBR was created to adjudicate cases in a fair and comprehensive manner as a joint board, operated and managed by the Air Force with representatives from each military Service. The Senate and House Armed Services Committee Staff suggested the Air Force manage the board since it had the fewest complaints about the DES and was seen as a logical choice.[76] Other Service critics argue that the Air Force is the most "generous" Service regarding rating decisions.[77] Regardless of who administers the PDBR, the benefit of this joint board construct is that decisions are not made by any one Service and are therefore inherently more consistent across the board. This logic would hold true for a joint PEB.

The PDBR is currently the only joint board in the DoD.[78] In the first two years of operation, the PDBR has demonstrated the feasibility of the joint Service board construct. Of even greater value is the impact this board has had on veterans. The PDBR has developed a construct where the Service interest is preserved, while at the same time proving that a joint board can eliminate Service redundancies and inconsistencies by applying a common standard to all cases. In 2008, the Undersecretary of Defense for Personnel and Readiness, David S. C. Chu called the board an important step in ensuring affected service members are treated fairly. "The PDBR has no greater obligation to our wounded, ill and injured service members and former service members than to offer fair and equitable recommendations pertaining to the assignment of disability ratings."[79]

The PDBR is made up of eight uniformed members- two Air Force officers, two Navy/Marine Corps officers, an Air Force Chief Master Sergeant, and three Army officers (due to the greater number of Army cases). There are also four civilian adjudicators and five

administrative support staff. Broad processing capacity of this core group of assigned personnel is approximately 30 cases a month.[80] In an effort to reduce case processing times, 16 civilian contractors were hired to prepare cases for adjudication by the PDBR voting board members. This augmentation has brought the adjudicated caseload up to 100 per month.[81] It is also important to note there are an additional six Air Force support staff in San Antonio that collect the documents and upload them into the electronic system. The board receives approximately 900-1,000 cases per year with the potential for 68,000 cases to be reviewed in total over the lifetime of the board.

One of the key efficiencies in the construct is leveraging the use of off-the-shelf technologies with the purpose of broadening the use of telecommuting for all PDBR members. Medical professionals are a critical asset to this work and are often the limiting factor across the DES. Technology has allowed the PDBR to train and equip physicians and nurses who reside outside of the PDBR commuting area to prepare cases for adjudication by the board. Reservists are also being used in this capacity, both preparing and adjudicating cases from across the country. This construct alleviates the fiscal burden of travel and per diem, as well as the requirement for physical office space. Within the coming months the PDBR will be relocating to Andrews Air Force Base where there will only be room for 16 personnel. This will force significantly more of the work to be accomplished remotely and will save the DoD more than one-quarter of a million dollars annually in leased office space alone.[82]

Another benefit to the joint board is the capacity to ensure equitable decisions across the Service components. Each board is comprised of three military officers in the grade of 0-5/0-6 (or civilian equivalents – all of whom are retired military officers). The Board president is a Colonel/Captain (0-6 or civilian equivalent) and is required not to be from the member's Service.

One medical officer and two line officers are the standard make up of each panel. Each member is afforded one vote and all votes are equal. The majority decision becomes the recommendation to the Service, with a minority report as deemed appropriate.

The PDBR's decision is not appealable within the DoD. PDBR President Mr. Mike LoGrande says, ". . . this is the reason the boards review is so painstakingly thorough. We must ensure we are affording each applicant the due process, fairness, equity and justice to which they are entitled."[83] He estimates that the PDBR spends on average 30 hours per case compared to one hour for a typical PEB. This is attributable to the depth in which the documents are reviewed. The PDBR currently adjudicates, on average, four cases per day. Given this ratio he estimates a Joint PEB, with a similar construct, could adjudicate an average of 28 cases a day.[84]

Challenges to the Joint Construct

Despite the drive by Congress for a joint board, the ultimate decision still resides with the individual Services. The PDBR's decision is only a recommendation to the appropriate decision authorities (Director of the Review Board Agencies for Army and Air Force, Assistant Secretary of the Navy or Assistant General Counsel for the Navy). Some would argue that this parochialism circumvents the reason for the PDBR. To date, the Air Force has accepted 100% of the recommendations, the Army 98% and the Navy 81%.[85] Failure of the Services to adopt PDBR recommendations on a more consistent scale results in an inequity for service members across the DoD, which opposes the very reason Congress directed the DoD to implement the PDBR in the first place.

Parochialism is a consistent challenge for joint operations across the Services. It is difficult for individual Services to relinquish power and control, even with the promise of equal

contribution. This is especially true when it comes to making decisions about service members and their treatment. Col Gail Gerding, former Army PEB President and current PDBR board member, explains that the Services are likely to be resistant to change because they want to, ". . . take care of their own."[86]

Another challenge is funding, both of the board and of the military retirement. One detractor to the construct of the Air Force managing a joint board is the constant concern for funding at the Service level. If the board was administered within the Office of the Secretary of Defense (OSD) and not by the Air Force, the funding could be more specifically directed based on Congressional demands.

A result of the PDBR process is that many of the applicants have had their cases re-characterized to a disability retirement due to an increase in their disability rating to 30% or greater. The Navy and Air Force re-characterization rates are close to 50%, with the Army rate significantly higher at 65%.[87] Many critics on the VA side feel that the high costs of military retirement (as described in section 2) are the reason for unreasonably low disability ratings by the Service PEBs. Medical benefits are not discretionary; the Defense Department must cover the costs. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, says, ". . . increasingly, it's having a direct impact on the department's ability to meet its needs for equipment, replacement equipment and personnel."[88] The USAPDA, which oversees the Army evaluation system, vehemently disagrees with this claim. Col Carlton Buchanan, Deputy Commander of the USAPDA, says instead that, "No one has discussed that financial burden with me at all . . . nobody has said I have a particular requirement or goal or quota or threshold that I can't surpass . . . I feel no pressure whatsoever to set limits on disability. We will do what is right."[89] This is not a direct challenge for the PDBR since they do not fund the military

retirements, but adds to the consternation over low rates of recommendation acceptance, as indicated previously.

CHAPTER IV
ANALYSIS

There are three main criteria for analyzing the question of shifting to a Joint PEB. First is the necessity for standardized and consistent ratings for all service members across the DoD. Second is the goal of reducing the DES timeline in order to better serve the service member. Third is an assessment of the potential cost savings incurred by the transition.

Criteria I – Standardization and Consistency

As previously addressed, one of the predominant factors driving the Wounded Warrior Legislation was identified inconsistencies in disability ratings for similar medical conditions. The Congressional mandate to ensure rating consistency is one of the main attributes for approval of a joint PEB. The IDES pilot program has proven the efficacy of utilizing a joint construct to ensure consistency of disability ratings. By FY12 the DES will be fully integrated with 100% of the disability ratings determined by the VA. The continuation of this collaboration with further integration into a joint PEB would therefore be in line with current Congressional and OSD directives.

According to Mr Robert Gaines, Office of the Assistant Secretary of the Navy (Manpower and Reserve Affairs), in FY10 when you compare the medical retirement percentages in the legacy system to the IDES they are consistently within 5% of each other (see figure 5).[90] This similarity between DoD and VA ratings, as they are used for adjudication, demonstrates improved use of the VASRD, as well as enhanced consistencies in the Service PEBs. This is especially noteworthy when compared to the statistics identified in figure 5 from 2007, when the Army medically separated 68% of cases, as compared to 31% in 2010.[91] This

severe shift demonstrates the reason for the higher re-characterization rate by the PDBR on Army cases described in section 3. Removing the determination of the disability rating from the workload of the PEB is a major step toward greater transparency; however, it does not ensure consistency in the conditions deemed unfitting and therefore ratable.

DISPOSITION BY MILITARY DEPARTMENT BY FISCAL YE							
Empirical Data (combined Active and Reserve Components)							
		2006	2007	2008	2009	2010	
						Legacy	IDES
Army	Fit/Return to Duty	955	912	1,005	1,073	603	227
	Separated with Severance	6,690	6,532	5,685	4,542	2,516	840
	Separated without Severance	742	559	321	143	83	20
	Permanent Disability Retirement	458	552	1,363	1,969	2,226	743
	Temporary Disability Retirement (TDR)	1,604	1,845	2,718	4,455	2,977	764
	Total Not Including TDR Re-evaluation	**10,449**	**10,400**	**11,092**	**12,182**	**8,405**	**2,594**
Navy	Fit/Return to Duty	1,263	1,290	972	636	487	240
	Separated with Severance	1,838	1,563	1,622	1,342	1,064	488
	Separated without Severance	301	313	235	144	126	42
	Permanent Disability Retirement	129	87	91	116	119	278
	Temporary Disability Retirement (TDR)	1,693	1,678	1,575	1,650	834	486
	Total Not Including TDR Re-evaluation	**5,224**	**4,931**	**4,495**	**3,888**	**2,630**	**1,534**
Air Force	Fit/Return to Duty	1,755	1,756	1,361	857	763	58
	Separated with Severance	1,080	1,145	881	814	867	68
	Separated without Severance	237	278	132	98	127	7
	Permanent Disability Retirement	397	657	570	516	662	75
	Temporary Disability Retirement (TDR)	483	755	1,052	860	917	94
	Total Not Including TDR Re-evaluation	**3,952**	**4,591**	**3,996**	**3,145**	**3,336**	**302**
	GRAND TOTAL NOT INCLUDING TDR RE-EVALS	19,625	19,922	19,583	19,215	14,371	4,430

Figure 5 –PEB Disposition by Military Department Chart (Reprinted from a chart developed by Mr Robert Gaines, Office of the Assistant Secretary of the Navy (Manpower and Reserve Affairs).)

Although the new IDES has been proven faster and fairer, there are still differences in the final, combined DoD and VA disability percentages.[92] By law the DoD can only consider conditions that are unfitting when determining disability ratings. The VA, on the other hand, determines disability ratings for all Service connected conditions, even those that would not be deemed an unfitting condition. For this reason, despite the integrated system and the VA now determining the disability ratings, the DoD and VA will often come to different final combined disability ratings.

In the current PEB system, each Service determines fit/unfit and also which conditions fall into each of these categories. For example, a service member with back, ankle and wrist injuries could be determined unfit for the back injury, but the ankle and wrist issues may not be deemed unfitting. The VA might rate the back injury as 10% disabling, with an additional 10 % each for the ankle and wrist injuries. The final combined disability rating from the DoD would therefore be 10 %, whereas the final combined disability rating from the VA would be 30%. The Service could separate this service member with a 10% disability rating. Even though the VA is now determining the disability ratings for each condition, there will still be the question of consistency of condition inclusion into the unfitting determination by the Service.

Utilizing the IDES and the PDBR as a benchmark to enhance consistency and transparency, there are clear benefits to following this model toward a joint PEB construct. There are, however some challenges to overcome.

One of the primary concerns of a joint construct, shared by each Service PEB, was removing the control of the fit/unfit decision from the individual Service. There were a number of reasons voiced for this concern. Primarily, board members felt it would be difficult for board officers from other Services to know if an individual service member would be able to do his or her duty with the medical condition presented. This concern speaks to the vastly different requirements of military career fields across the Services. Outside of a few overlapping duties, there are few similarities in career fields. For example, it may be difficult for an Air Force board officer to make a fit/unfit determination on a Navy electrical technician assigned to submarine duty. The Air Force officer may not be aware of the physical requirements of each Navy, Army and Marine Corps occupational specialty. Associating fit/unfit determinations with a service members' career field and rank creates an obvious challenge for a joint board.

In order to address this concern, a joint PEB could mandate two out of the three board officers must be from the covered individual's same Service. This solution accomplishes two things. First, it ensures that each Service maintains the majority voting power for their service members, the number one concern for both the Army and Air Force PEBs. Second, it allows the line officers to consider the non-meritorious issues of the case, as well as the conditions that would be unfitting for the specified career field. The organization of the PDBR ensures at least one member of the board is from the covered individual's Service to address these same issues.

Criteria II – DES Timeline Reduction

The second criterion addresses the goal of reducing the DES timeline. Dr. Clifford L. Stanley, Undersecretary of Defense for Personnel Readiness, set a 180 day goal for the DES process.[93] The pilot IDES program reduced the process timeline by 47%, but the workflow still took an average of 271 days to complete. In order to reduce this workflow by the additional 44% necessary to meet Dr. Stanley's goal, significant efficiencies must be utilized. Once again, using the IDES as a benchmark, streamlining the system to a joint PEB would continue this effort. There are residual changes that would be necessitated by such a transition, including the creation of a common electronic record and tracking system, a central administrative staff for funneling the caseload, and a single checklist of requirements for the overall PEB process.

Currently all of the Service PEBs still use paper records to adjudicate their cases. The cases forwarded through the IDES are partially electronic, but the Service Treatment Records (STR) are often still in paper form. The copying, shipping, tracking, storing and securing of these paper files creates a tremendous burden on the administrative staff and also significantly delays the process. A paper system uses considerable resources and also costs the Services in

courier fees and administrative costs. The potential for enhanced interoperability is outlined in depth in section 2 and would be a necessity not only for a joint PEB construct to be possible, but also to ensure its efficiency and effectiveness.

The IDES integration is already laying the foundation for building such integrated computerized systems, although the individual Services have work to do in order to incorporate the change down to the MTF level. A paperless system would reduce the administrative workload at every level – physicians, MTF administrators, DES, VA and beyond. Electronic capabilities create efficiencies for adjudicators in searching for key words, particular physicians or treatment on specific days, allowing for faster processing times per case. Geographically separated board members could easily identify particular points, move files and share information with other review officials. Implementing an electronic capability of this nature holds the key to a drastic reduction in case processing time.

The PDBR is a case in point. All paper documents are scanned into the system at the main processing center in San Antonio, Texas. There is a time and manpower investment in the initial scanning process; however, once the documents are uploaded into the system the majority of the administrative work is complete. The use of electronic records also allows the PDBR to utilize the expertise of personnel not physically located in Washington D.C. Many of the medical professionals and some of the line officers telecommute from home, allowing the PDBR to tap into vast personnel resources without paying travel, per diem, cost of living, and full time salaries. The PDBR can additionally utilize a well-trained Reserve officer pool when there are surges in the workload.

Utilizing electronic documents allows personnel working a case to book-mark, flag and sort the information quickly and effectively. It also enhances the ability to share and track the cases as they route through the system. Another tool the PDBR utilizes effectively is the Case Management Tracking System (CMTS) software. The CMTS helps organize, manage, distribute and track the cases from the time they are scanned into the system, until a board decision is reached and they are forwarded on for final approval. The CMTS, or a similar system, would allow for easy integration of the virtual records being created by the new IDES. Due to the flexibility of the software platform, it would also tie together the STR's, VA documents and other Service forms into one easily managed packet. The Air Force PEB is currently investigating purchase of this system. It would be a key component to the success of a joint PEB.

Not only would virtual records create tremendous efficiencies for the DoD, but would also ensure consistent, long term care throughout a service member's life, both in and out of the Service. Rear Admiral Timberlake suggests that, "Departments believe they are close to settling on a dramatic new approach to information sharing that takes advantage of cutting-edge developments in the information technology industry to create a single virtual lifetime electronic record that captures a service member's relevant health and benefits information from the time of accession to the time of burial."[94] The current paper system often relies on the service member to find, maintain, organize and share their medical records once they leave the Service. These records contain important information for the long term health of an individual, especially if they have an injury or illness that was treated in the Service. If these documents are lost, a service member may find it difficult to get continued, consistent care in the civilian sector. This could

lead to worsening conditions, inability to get medications, relapses, or in the case of mental health issues, serious criminal behavior.

Another impediment is in the critical manning of the medical professionals who review the cases. According to a statement made to the House Armed Services Committee by Chief of Naval Personnel, Vice Admiral Mark E. Ferguson III, U.S. Navy, on March 17, 2011, "Health care professionals remain a recruiting priority through FY12."[95] Recruitment of Navy and Marine Corps medical professionals for the current fiscal year is only at 43% of end goal requirements. Vice Admiral Ferguson III requested $253.7M from the FY12 budget for special and incentive pay to attract and retain these critical medical professionals.[96] According to LtCol Hargett, it is difficult to attract and retain medical officers to the PEB because of critical manning in the Services and low salaries on the civilian staff.[97] A joint PEB, with shared medical professional staff, would consolidate efforts and potentially reduce the overall manning requirement.

Labor pooling is one of the primary efficiencies created by merging to a joint PEB, saving both time and money. A major issue identified by each Services PEB director was the need for more personnel, especially medical and administrative staff. A joint PEB would pool the critical personnel into one central place, reducing the overhead costs of operating various centers and enjoying the benefits of combined resources toward a shared goal.

The PDBR provides a good case study into the concept of labor pooling. In the past year, the PDBR added sixteen- full-time equivalent- civilian contractor positions, six of whom are nurses and ten of whom are physicians, all performing the medical investigations.[98] This augmentation brought the workflow up to over 100 cases a month, a 233% increase with only a

57% increase in personnel. Extrapolating this personnel workload ratio to a joint PEB demonstrates the potential for significant efficiencies. It is not possible to make a direct line comparison due to the substantial differences in time spent per case, because the PDBR averages 30 hours per case, while the PEB averages 3. This difference makes the ratio all the more poignant since the time spent per PEB case is only 10% of that the PDBR spends. Utilizing this ratio as a workflow prediction model, it is estimated that 1,000 cases per month could be achieved given a similar construct of 28 adjudicators. Pooling all three of the current PEBs' personnel would bring together approximately 50 adjudicators. Using the workflow ratio above, this combined personnel structure would manage an estimated 1,780 cases per month or 21,400 per year. This is well over the 18,800 cases adjudicated in FY10, meaning a reduction in personnel would be possible. Another alternative to reducing the adjudicator workforce would be to maintain the total combined personnel structure in order to create a buffer mechanism to manage the surge capacity, thereby improving the DES timeline.

Since there are often inefficiencies in administrative processing, the pooling of administrative personnel would also allow for faster processing times and a reduced backlog. Overhead traditionally does not go up on a 1:1 ratio with personnel. Utilizing the Army Corps of Engineers labor management equations, the general and administrative overhead rate is calculated by dividing the general and administrative costs/personnel by the direct labor costs/personnel.[99] With a ratio of 6 administrative staff to 28 direct labor staff on the PDBR board, this overhead ratio is 21%. As an organization grows the overhead ratio generally stays about the same, thereby creating significant economies of scale as the organization numbers climb. For example, if the joint PEB were to maintain the current structure of approximately 50 adjudicators, this ratio would predict that 11 administrators would be sufficient. This is a

significant reduction in administrative staff when compared to the 50 plus administrative personnel currently supporting the three Service PEBs.

Since it is not an isolated process and many administrative staff support the DES, these estimates are simplified and may not take into account all of the actual personnel who currently support the various systems. It also does not take into account the new administrative requirements that would be created in the management of a joint PEB. Instead this ratio demonstrates the generalized economies of scale that a reduction in administrative overhead would make possible. It is difficult to estimate the potential savings in real dollars due to the variations in pay grade and structure of the various PEB administrative functions; however, it would be feasible to predict that the administrative overhead could be reduced by at least 40 – 50%.

Criteria III – Cost Savings and Efficiencies

The labor pooling concept not only reduces the DES timeline, but also demonstrates significant cost savings potential for the DoD. Reducing redundancies in administrative staff and overhead operating costs are two of the key efficiencies to a joint board and addresses the third criteria for assessment. Not only would there be a savings in the personnel costs, but also in the overhead required to support those personnel, ranging from computers, to work spaces and supplies. Merging to a single joint location would also reduce the facility costs incurred by the six separate PEBs under their current operational constructs. This would also allow pooling of resources such as copiers, scanners, networks, and other necessities. The most important pooled resource is that of the highly trained personnel that would now be available to cover surges in overall cases, FPEBs, etc.

A single, joint PEB location would also create opportunities for increased use of technology, such as video teleconferencing (VTC) for IPEBs and FPEBs. Many of the PDBR staff use VTC on a regular basis to work outside of the Washington D.C. area. Use of this technology allows for greater cost savings in overhead and support structure. Mr. LoGrande identifies use of the VTC, ". . . as one of the most significant efficiencies of the joint PDBR" and recommends that it would be a critical factor in creating a joint PEB.[100] He cites the quarter of a million dollar savings the PDBR is making in 2011, by reducing their footprint and relying heavily on VTC, as evidence of the monetary benefits. Using this model, the reduction of the current five PEB locations to one might garner savings in excess of five times this amount.

Another possible use for VTC is in the FPEB. Service members and their lawyers could utilize a VTC system as an alternative to physically being present at the board. VTC would reduce travel, per diem and legal costs, while still providing members the opportunity to state their case and hear the PEBs decision face-to-face. Members could be given the option to appear in person or choose the VTC.

A final issue that is linked to both time and cost savings would be the elimination of costly backlogs. LtCol Leslie Hargett is very focused on meeting the 40 day standard workflow processing time for two reasons. First, he feels it is what is best for the service member. Second, he makes the case that there are significant costs associated with members in the system even a day more than necessary.[101] A recent Air Force audit determined that the Potential Monetary Benefit (PMB) of adjudicating cases within the 40 day window is $172,116,673.[102] According to the FY10 Air Force Audit report, "PMB is achieved through a reduction in the composite pay rate for personnel who would have separated or retired, had their IPEB determination been processed within the 40 day requirement . . . and is offset by the costs

associated with severance and retirement payments, and the cost to fund a civilian physician through FY11 to support IPEB case reviews."[103]

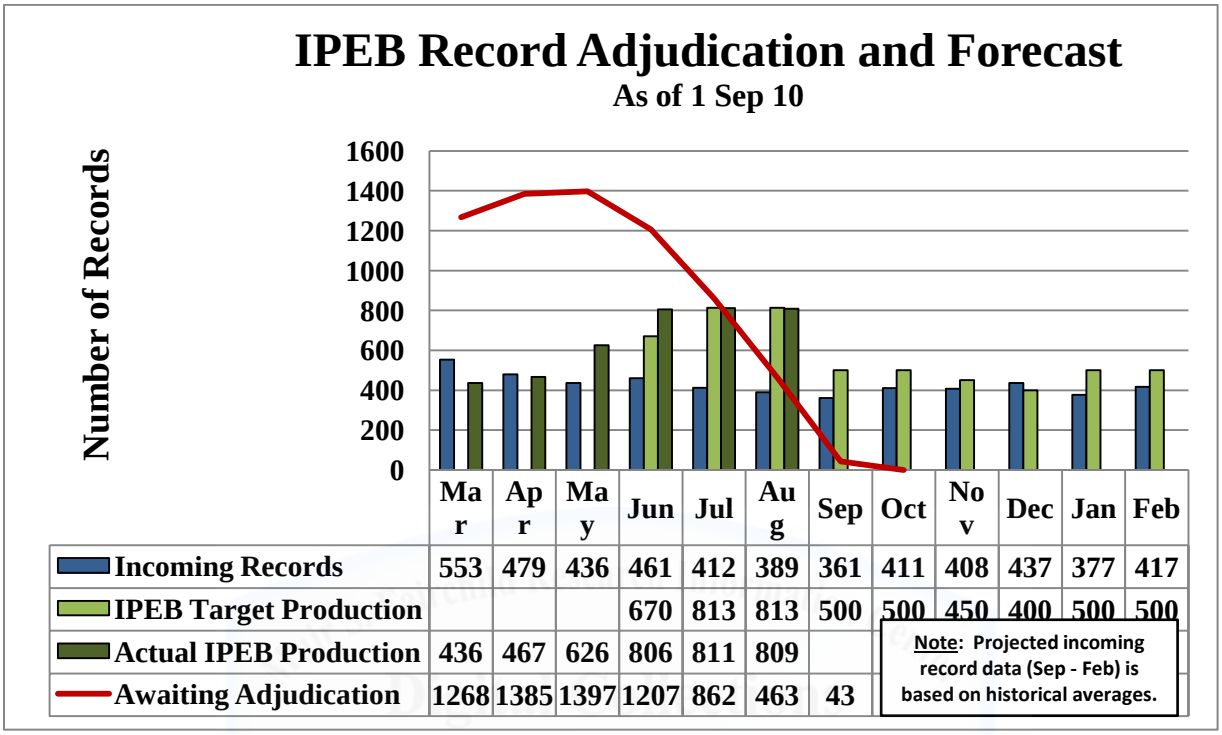


Figure 6. 2010 Air Force IPEB Record Adjudication & Forecast (Reprinted from an Air Force Audit Agency Report of Audit, Review of Disability Evaluation System Internal Controls(Project F2010-FD2000-0255.000).)

Figure 6 highlights the Air Force backlog of 1,400 cases in FY10 leading to an extended processing time of 152 days. LtCol Hargett estimates this backlog cost the government $74 million.[104] Deliberate workload planning and assessment of the PMB produced a precipitous drop to 81 days as of September 2010 and by March 2011 they had reached the 40 day goal.[105] This example demonstrates the significant costs associated with backlogs in any Service. It also identifies the additional savings to the DoD of moving to a joint board that would have the appropriate personnel to meet the workflow mandates.

CHAPTER V
COMPARISON OF OPTIONS

No Change

The first option to consider is maintaining the system as it currently stands. The IDES implementation is already creating consistencies in the disability ratings, thereby establishing greater transparency for the service member and Congressional oversight. The integrated system is also reducing the overall processing days for a case. During the IDES pilot program the average processing time was reduced to 271 days. This may be markedly better, but still far exceeds Mr. Stanley's goal of 180 days. Workflow on the DoD side would continue to be a challenge. Based on past history, as noted in figure 7, the potential exists for surges to at least double the standard processing time set by Congress. This could be managed through increased staffing and greater use of technology, both of which were identified as challenges by LtCol Hargett. Without either of these changes, the Services would be spending millions of dollars due to long processing times and backlogged cases, as was outlined by the Air Force audit discussed in section 4. Finally, the costs associated with the process would remain the same.

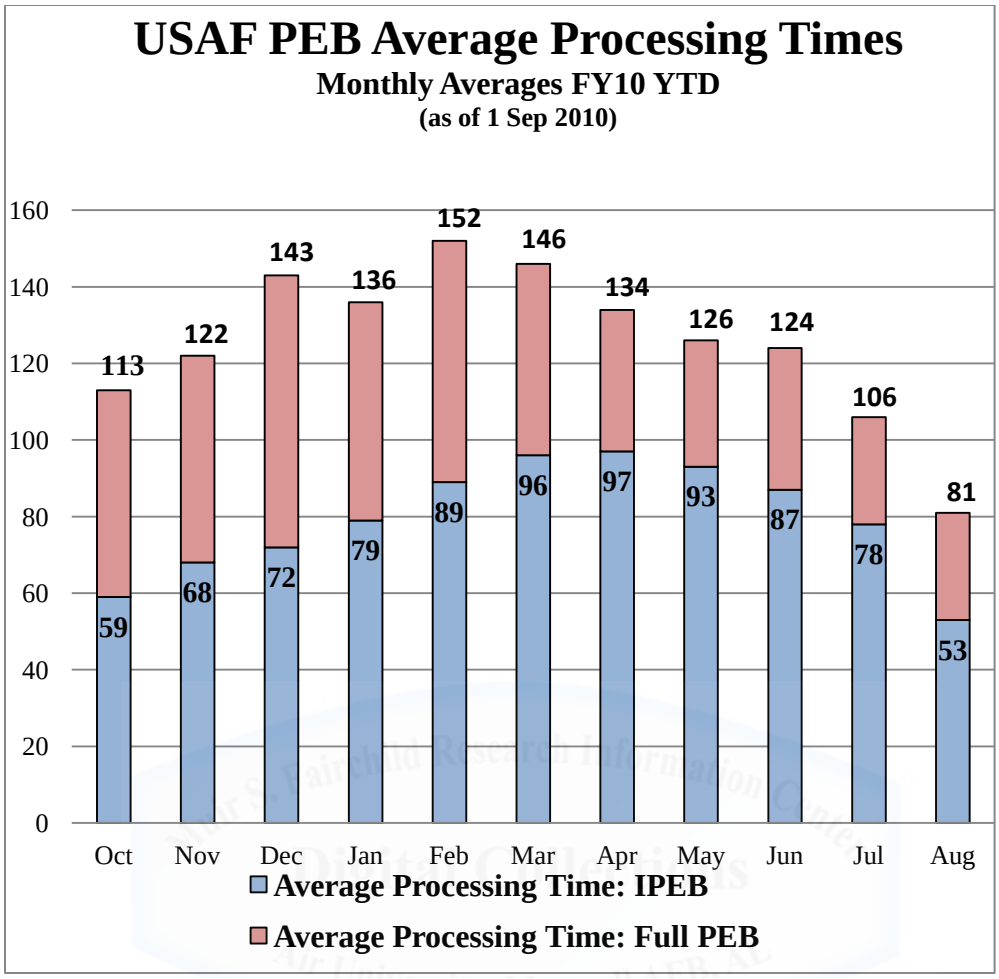


Figure 7. Air Force PEB Average Processing Time (Reprinted from an Air Force Audit Agency Report of Audit, Review of Disability Evaluation System Internal Controls(Project F2010-FD2000-0255.000).)

Joint Formal PEB Only

The second option is to transition to a joint FPEB, while leaving the current structure for the IPEBs intact. This change would create an appellate level joint board very similar to the PDBR. The main difference would be the service member's right to legal counsel and right to an appearance at the FPEB. This change would have very little impact on the consistency of rating decisions. In fact, having a joint board potentially overturning the Services' decisions could lead to increased parochialism. The PDBR is a good example. Despite the PDBR's mandate by Congress, the individual Services still maintain the power to accept or deny the board's

recommendations. As detailed previously, the Department of the Navy has only accepted 81% of the PDBR's recommendations to date.[106] There is no doubt that a joint FPEB, without a joint IPEB, would certainly face similar parochial challenges.

Another concern is on the side of the service member facing not a board of their peers, but a joint board. This could be especially confusing since the FPEB is the first and only direct contact the service member has with anyone in the DES process. Despite the ability to organize a joint FPEB to ensure representation by the service members' Service, there could still be discomfort as an infantryman facing a board with Navy or Air Force officers. There is already a gap where enlisted personnel facing a board are concerned with officers understanding what they have been through. This division is evidenced in various comments on the *pebforum.com* website where enlisted service members going through the system interact to share information and discuss issues.[107] Service members facing a board of officers in different uniforms could add to the confusion and stress.

Since it is likely the final decision would still reside with the individual Services, as it does with the PDBR, it would become very confusing for a Service IPEB to make a decision that is appealed to a joint FPEB and then have that decision sent back to the Service for final approval. This would be especially difficult if electronic documents and tracking systems were not implemented by all of the Service IPEBs. Since a service member cannot contest their disability rating percentage, the FPEB would only be evaluating the question of fitting versus unfitting condition inclusion.

In consideration of the workflow criteria, it is difficult to see how a joint FBEP would save much time. According to Col Gerding, approximately 10% of Army service members

request an FPEB following their IPEB.[108] The Navy/Marine Corps figure is similar. The Air Force experiences slightly higher appeal rates, averaging 20% per year.[109] This means, on average, there could be 2,500 FPEBs a year. Both the Air Force and the Army currently have a two to four week standard interval between the IPEB and the FPEB. This fluctuates based on backlogs and has been as high as 120 days according to LtCol Hargett.[110]

The main limiting factor in this waiting interval is the availability of legal representation. According to LtCol Hodge, formal boards would be able to meet a higher caseload, but the lawyers are restricted to just two cases a day.[111] Changing to a joint board, and even adding more board personnel, would do little to streamline the process unless the critical manning of the legal professionals is also addressed. A GAO Report from 2008 solidifies this claim, stating, "In addition to gaps in board liaisons and board physicians, staffing of legal personnel who provide counsel to injured and ill service members throughout the disability evaluation process is currently insufficient."[112]

Due to the unpredictability of the caseload for a formal board there could be significant inefficiencies to a joint FPEB. Given the unique aspect of a joint board construct there would be no capacity to share personnel with the IPEB process during slower times since they would still be run by the individual Services. Likewise, there would be no mechanism for adding temporary personnel from the IPEB during surge times. Not only do these limitations impact the workflow, but also the costs associated with such a construct.

There would however, be significant cost savings in merging the various individual Services' formal PEBs to one location, creating a single level of overhead administration. Using the administrative prediction modeled identified in section 4, there would likely be redundancy

in administrative staff, saving both in personnel costs and facilities costs. Given the limiting factor of the legal representation, there would likely be the capability to reduce a few of the board personnel from the current total as well. The pooling of personnel and resources causes significant efficiencies, as outlined in section 4. If VTC technology was used successfully, there would be significant cost savings in travel, TDY, per diem, lodging, etc. Since this is not an aspect likely to be mandated in the process it would be difficult to forecast the potential savings based on the individual service members requests.

Joint IPEB and FPEB

The last option is a fully integrated PEB system. Given the new IDES, it is unlikely that a joint PEB would enhance the consistency much more than the IDES already has. Statistics from figure 5 support this claim. Board members from different Services may draw on different backgrounds and experiences in making their fit/unfit condition assessments, which could add value; however, without the appropriate board construct it could also create greater problems for the individual Services. As was previously mentioned, it is difficult for Air Force officers to understand the intricacies of Army or Navy functions, and vice versa. For example, if a board was to determine a soldier fit for duty with a back injury and return him or her to duty, the Service would then be forced to find him or her an appropriate position. Making an assessment of this nature within the Service has its consequences, but a joint board making this assessment could lead to far greater parochial issues than already exist.

From a workflow standpoint however, there would be significant enhancements. Pooling all of the PEB resources into one facility with a larger pool of administrators, adjudicators and medical professionals would create opportunities to deal with caseload fluctuations. This is

especially important given the critical manning of medical professionals in the system. One Army PEB currently averages 20-25 cases a day with 5 adjudicators and 4 administrative staff.[113] The Air Force PEB also averages 20 cases a day with 7 adjudicators and 11 administrative staff.[114] With double the adjudicators and 14 administrators, the Navy averages 30-50 cases per day. These variations demonstrate the inconsistencies in workflow across the current Service PEBs and the capacity for improvement once pooled.

One of the most challenging aspects of managing the workflow of the PEB process is dealing with the surge capacity of cases entering the system. Since this rate cannot be predicted or managed, it is critical to have a personnel force that can react accordingly. One of the major benefits of a joint PEB would be the flexibility to handle the variation in surges between the individual Services. Given the different deployment and training cycles in the Army, Air Force, Navy and Marine Corps cases enter the DES at different times a year. Utilizing a pool of joint adjudicators would allow for greater flexibility in workflow management and help maintain a steady, predictable outcome.

In order for a joint PEB to work, the system would need to be a managed, paperless process that would inherently lead to significant time savings and efficiencies of its own accord. Streamlining the process from a joint VA/DoD evaluation system directly into a joint PEB system would also reduce redundancies and contact points. A joint PEB would create one contact point for the VA, thereby reducing administrative interfaces with each Service directly. This would also promote the use of a single workflow management system that could track the case through the entire process, all electronically. A significant cost savings would be incurred by developing one workflow management process for the entire system, versus the money that

each Service is currently spending on their own technology that may not easily integrate in the future.

There is a tremendous cost savings potential in merging three organizations into one. This extends across the board from facilities and material costs, to administrative and management costs as outlined in section 4. Given the workflow benefits addressed previously, there would be potential monetary benefits to meeting caseload goals and reducing the process timeline as well.

CHAPTER VI
RECOMMENDATION

It is the recommendation of this paper that a joint IPEB and FPEB construct should be implemented. The validity of a joint construct is clear against the benchmark of the IDES and PDBR. The IDES and PDBR joint constructs have demonstrated enhanced simplicity, reduction of the adversarial nature of the DES process, faster and more consistent evaluations and compensation, seam-less transition to veteran status and a more service member-centered system.[115] These are the very same attributes a joint PEB would bring to the process. The evidence suggests there would additionally be significant financial savings to the DoD through the pooling of resources, reduction in redundancies, and efficiencies created by a joint system. This construct is also in line with the joint DoD/VA IDES system and current OSD and Congressional directives. Finally, a joint PEB is also the answer to Dr Stanley's mandate for reducing the timeline to better serve the service member.

Not only does a joint PEB make sense financially, but it better serves the service members, perhaps in more ways than one. A joint construct also creates other opportunities not inherent in the current system. An additional recommendation is the idea of leveraging previous government training and parlaying it into a career in another Service.[116] For example, if a soldier in the Army is not able to do his or her specialty due to a knee injury, is there a desk job in another Service that he or she could fill? According to DoD figures, ". . . the cost of recruiting new Service members averages about $11,000 each . . . combined with an average cost of initial entry training at $35,000, DoD's investment in military recruit accessions and training is enormous since more than 200,000 of America's youth are recruited for active military service each year."[117] Given this $46,000 initial investment made in each service member, there is a

significant incentive to consider the possibility of retaining the skilled and trained assets within the DoD when possible. Certainly this would not be the case with every individual meeting a PEB. If only 5-10% of the individuals meeting the board were eligible and amenable to such a cross-flow, the DoD would save $46 to $92 million dollars in investment costs and also reduce recruitment demands.

In order to create the greatest efficiencies, the following recommendations affect the board construct. In order for individual Services to maintain control of the fit/unfit decision, it is recommended that two members of the three person board would be from the same Service as the covered individual. The joint IPEB would operate from a single facility, preferably located within commuting distance of co-located bases. The board members would therefore be afforded easy access to military facilities. This could be Washington D.C., given the joint nature of the region; however, the high cost of living may be a detractor to such an arrangement. Atlanta might offer a more affordable option. The use of technologies such as VTC would reduce overhead costs further and also pool highly trained personnel from across the nation.

A further recommendation would be for a Virtual Lifetime Electronic Record system to be implemented across all MTFs and utilized throughout the DoD and VA processes. This solution fully integrates the system and allows easier recording and tracking of service members' healthcare both in the Service and into the civilian sector. Implementation of an electronic record system would allow for easier case management throughout the entire DES process through a common system such as CMTS or other available software. This would enhance tracking of workflow, identify bottlenecks, and inefficiencies in the system and would also provide greater transparency to the service member following their case.

The final recommendation is for pooling of the IPEB and FPEB board so that each can support the other, depending on workflow. This type of system requires greater flexibility, but elicits much greater efficiency. Since the workflow will always be unpredictable, it is critical to have buffers in place to adequately manage the surges when they occur. An argument could also be made for a mobile FPEB construct, allowing for travel to locations of high activity, such as Walter Reed Medical Center. This decision would be dependent on service members' acceptance in utilizing VTC technology.

One of the major challenges to this recommendation is in the transition process itself. The argument could be made that, since the overall case numbers have been trending down for the past few years (see figure 5), now is as good a time as any to make the change. Since the IDES implementation is also creating significant change in the coming year, it would be beneficial to make the transition to a joint PEB at the same time to ensure streamlining of processes between the two systems. In an interview with Col Gerding she identified two main challenges that seemed to resonate with the other PEBs, managing the movement of files and the potential inter-service power struggles.[118] The electronic system described previously would address the first logistical issue; however, the second does not present as simple a solution. It will take a serious commitment by each Service and positive direction from the DoD level, but the long term implications of such a transition are significant. The PDBR construct is a benchmark for what is possible and its' successes demonstrate the vast potential jointness affords. 1st Lt Andrew K Kinard, USMC (Ret) summed it up in his testimony before Congress:

> The senior leadership in the DOD and the Veterans Administration have done a remarkable job in breaking down institutional barriers in the last 2 years to provide the best access to services and address difficulties in case management. Unfortunately, this level of cooperation has not been institutionalized at the end-user level-that of the recovering servicemember- and many issues remain at that level with respect to access to

services and case management. Effective oversight of inter-agency coordination is essential as we move forward so that the men and women who have sacrificed so much are best equipped to recover, rehabilitate, and reintegrate as productive members of our society.[119]

Notes

[1] (Intrepid Fallen Heroes Fund n.d.)
[2] (Disabled American Veterans n.d.)
[3] (Disabled American Veterans n.d.)
[4] (Disabled American Veterans n.d.)
[5] (Span 2007)
[6] (Span 2007)
[7] (Span 2007)
[8] (SECNAVINST 1850.4E)
[9] (Gaines 2011)
[10] (Defense Manpower Data Center 2011)
[11] (Span 2007)
[12] (Hargett 2011)
[13] (GAO Report – Social Security Disability 2009)
[14] (Wounded, Ill and Injured Compensation and Benefits Handbook 2008) pg 8
[15] (GAO Report – DoD Disability 2001)
[16] (Gaines 2011)
[17] (Gerding 2011)
[18] (GAO Report – DoD Disability 2001)
[19] (TRICARE 2005)
[20] (GAO Report – DoD Disability 2001)
[21] (GAO Report – DoD Disability 2001)
[22] (Gaines 2011)
[23] (GAO Report – DoD Disability 2001)
[24] (GAO Report – DoD Disability 2001)
[25] (GAO Report – DoD Disability 2001)
[26] (Span 2007)
[27] (Span 2007)
[28] (Wounded, Ill and Injured Compensation and Benefits Handbook 2008)
[29] (Hodge 2011)
[30] (Hodge 2011)
[31] (Hodge 2011)
[32] (Hargett 2011)
[33] (Hargett 2011)
[34] (Hargett 2011)
[35] (Hargett 2011)
[36] (Gaines 2011)
[37] (Eckberg 2011)
[38] (Eckberg 2011)
[39] (Gerding 2011)
[40] (Gerding 2011)
[41] (Gerding 2011)
[42] (Panangala 2007)
[43] (Services 2009)
[44] (AP 2007)
[45] (AR 635-40 2006) pg 71
[46] (Physical Disability Review Board Training Manual 2010)
[47] (Murphy 2011)
[48] (Subcommittee on Personnel of the Committee on Armed Services United States Senate 2009)
[49] (Subcommittee on Personnel of the Committee on Armed Services United States Senate 2009)
[50] (Health.mil – PDBR Frequently Asked Questions)
[51] (Philpott 2010)
[52] (Philpott 2010)
[53] (LoGrande 2011)

[54] (LoGrande 2011)
[55] (Wounded, Ill and Injured Compensation and Benefits Handbook 2008)
[56] (GAO Report – Military Disability System 2008) pg 2
[57] (Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs 2009) pg 72
[58] (GAO Report – Military and Veterans Disability System 2010) pg 16
[59] (Hearing to Examine the Implementation of Wounded Warrior Policies and Programs Senate 2009) pg 73
[60] (Gaines 2011)
[61] (Hargett 2011)
[62] (Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs 2009)
[63] (Hargett 2011)
[64] (GAO Report – Military and Veterans Disability System 2010) pg 39
[65] (Wounded, Ill and Injured Compensation and Benefits Handbook 2008)
[66] (Michael E Kilpatrick June 2009)
[67] (Michael E Kilpatrick June 2009)
[68] (Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs 2009) pg 107 quoted by Sen Ben Nelson
[69] (Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs 2009) pg 107
[70] (Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs 2009)
[71] (Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs 2009)
[72] (Hargett 2011)
[73] (LoGrande 2011)
[74] (LoGrande 2011)
[75] (National Defense University Library n.d.)
[76] (LoGrande 2011)
[77] (LoGrande 2011)
[78] (LoGrande 2011)
[79] (Miles 2008)
[80] (Miles 2008)
[81] (LoGrande 2011)
[82] (LoGrande 2011)
[83] (LoGrande 2011)
[84] (LoGrande 2011)
[85] (LoGrande 2011)
[86] (Gerding 2011)
[87] (LoGrande 2011)
[88] (Span 2007) pg 4
[89] (Span 2007) pg 4
[90] (Gaines 2011)
[91] (Gaines 2011)
[92] (Wounded, Ill and Injured Compensation and Benefits Handbook 2008)
[93] (LoGrande 2011)
[94] (Hearing to Examine the Implementation of Wounded Warrior Policies and Programs2009) pg 80
[95] (VICE ADMIRAL MARK E. FERGUSON III 2011) pg 12
[96] (VICE ADMIRAL MARK E. FERGUSON III 2011) pg 15
[97] (Hargett 2011)
[98] (LoGrande 2011)
[99] (Cost of Doing Business Cookbook, US Army Corps of Engineers) pg13
[100] (LoGrande 2011)
[101] (Hargett 2011)
[102] (Ruiz 2010)
[103] (Ruiz 2010)
[104] (Hargett 2011)
[105] (Hargett 2011)
[106] (LoGrande 2011)
[107] (Parker 2007)

[108] (Gerding 2011)
[109] (Hodge 2011)
[110] (Hargett 2011)
[111] (Hodge 2011)
[112] (GAO Report – Military Disability System 2008) pg 13
[113] (Gerding 2011)
[114] (Hodge 2011)
[115] (VICE ADMIRAL MARK E. FERGUSON III 2011)
[116] (LoGrande 2011)
[117] (DoD about.com 2011)
[118] (Gerding 2011)
[119] (Hearing to Examine the Implementation of Wounded Warrior Policies and Programs 2009) page 11

Bibliography

Army Corps of Engineerings. “The Cost of Doing Business Cookbook.” http://www.swl.usace.army.mil/resourcemgnt/cookbook.pdf (Accessed March 21, 2011).

Associated Press. "Lawmakers Vow to Resolve Walter Reed Scandal." *MSNBC.com*, March 6, 2007.

Committee on Armed Services. *Hearing to Examine the Implementation of Wounded Warrior Polilcies and Programs: Hearing Before the Subcommittee on Personnel of the Committee on Armed Services, United States Senate.* 111th Cong, 1st sess., 2009.

Defense Manpower Data Center. "Statistical Information Analysis Division." *DOD Personnel & Procurement Statistics.* http://siadapp.dmdc.osd.mil (accessed March 20, 2011).

Department of Defense. "US Military." http://usmilitary.about.com (accessed March 28, 2011).

Disabled American Veterans. www.dav.org (accessed March 19, 2011).

DoD and VA joint handbook. "Wounded, Ill and Injured Compensation and Benefits Handbook". 2008. Accessed online at: http://www.disability.gov/viewResource.

Eckberg, LtCol Stephen, USMC, interview by Maj Elizabeth Blanchford. *Former Navy/Marine Corps PEB, Currently PDBR Board Member* (April 8, 2011).

Ferguson, Vice Admiral Mark E. III, U.S. Navy. *Statement Of Vice Admiral Mark E. Ferguson III, U.S. Navy, Chief Of Naval Personnel and Deputy Chief Of Naval Operations (Manpower, Personnel, Training & Education) Before the Subcommittee On Military Personnel Of The House Armed Services Committee On M.* Statement to the House of Representatives, Washington DC: House Armed Services Committee, 2011.

Gaines, Dr Robert. *Disposition by Military Departments by Fiscal Year*, Power Point Chart, 2011.

Gerding, Col Gail, interview by Maj Elizabeth Blanchford. *Former Army PEB President, Currently PDBR Board Member* (March 21, 2011).

Hargett, LtCol Leslie, interview by Maj Elizabeth Blanchford. *Director Air Force Physical Evaluation Board* (March 21, 2011).

Hodge, AF LtCol Lorainne, interview by Maj Elizabeth Blanchford. *AF PEB Adjudicator* (March 24, 2011).

Intrepid Fallen Heroes Fund . www.fallenheroesfund.org (accessed March 19, 2011).

LoGrande, Mr Mike, interview by Maj Elizabeth Blanchford. *PDBR President* (March 18, 2011).

Michael E Kilpatrick, M.D., Director of Strategic Communications for the Military Health System in the Office of the Assistant Secretary of Defense for Health Affairs. "The DoD/VA Interagency Program Office: Making Strides for the Future of Health Care Information." *U.S. Medicine - The Voice of Federal Medicine*, June 2009.

Miles, Donna. *U.S. Department of Defense.* July 1, 2008. www.defense.gov (accessed March 8, 2011).

Military Health System, DoD. "Physical Disability Board of Review Frequently Asked Questions" Health.mil. http://www.health.mil/Content//docs/PDBR%20faq.pdf (Accessed March 18, 2011).

Murphy, Patricia. "Weight of War: Soldiers Heavy Gear Packs on Pain." *NPR.org*, April 10, 2011.

National Defense University Library. www.ndu.edu/library (accessed March 12, 2011).

Secretary of the Navy (SECNAVINST) 1850.4E. *Department of the Navy Disability Evaluation Manual.* April 30, 2002.

Panangala, Sarah A. Lister and Sidath Viranga. *Comparison of "Wounded Warrior" Legislation:.* CRS Report to Congress, Washington DC: Congressional Research Service, 2007.

Philpott, Tom. "PTSD Vets Win Retirement Deal." *Military.com*, January 28, 2010.

Physical Disability Board of Review. *Physical Disability Review Board Training Manual.* 2010.

Ruiz, Tammie Johnson/Elvis. *Disability Evaluation System Internal Controls.* Audit Report, Brooks City-Base, Texas: Air Force Audit Agency, 2010.

Span, Paula. ""Battle Worn"." *The Washington Post*, February 25, 2007.

TRICARE. *Fit For Life - Healthy Force/Healthy Families.* 2005 Tricare Stakeholders Report, TRICARE, 2005.

U.S. Army Regulation (AR) 635-40. *Physical Evaluation for Retention, Retirement or Separation.* Washington DC: Department of the Army, February 8, 2006.

US Senate. *Hearing to Examine the Implementation of Wounded Warrior Policies and Programs: Hearing before the Subcommittee on Personnel of the Committee on Armed Services.* 111th Congress, First Session. 1st sess., 2009.

United States General Accounting Office. *DOD Disability - Overview of Compensation Program for Service Member Unfit for Duty.* Report to the Chairman, Committee on Armed Services, House of Representatives, Washington DC: GAO, 2001.

United States Government Accounting Office. *Social Security Disability - Additional Outreach and Collaboration on Sharing Medical Records Would Improve Wounded Warrior's Access to Benefits.* Report to the Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, Washington DC: United States Government Accountability Office, 2009.

United States Government Accountability Office. *Military Disability System - Increased Supports for Servicemembers and Better Pilot Planning Could Improve the Disability Evaluation Process.* Report to Congressional Requesters, Washington DC: GAO, 2008.

United States Government Accounting Office. *Military and Veterans Disability System: Pilot Has Achieved Some Goals, but Further Planning and Monitoring Needed.* Report to Congressional Committees, Washington D.C. : GAO, 2010.